

**Location**

Camillus
Liverpool
New Hartford
Watertown

For new referrals, please include recent labs and last two office visit notes.

Fax completed form to (315) 457-4305

Phone (315) 457-3091

1. PATIENT INFORMATION

Name:	DOB:
Phone:	Other Phone:
Email:	
Social Security #:	Allergies:
Gender: M F	Weight: Lbs Kg
Patient Status: New to therapy Continuing therapy Next due date (if applicable):	

2. INSURANCE INFORMATION (required)

Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

3. PHYSICIAN INFORMATION

Physician Name:		NPI#:
License #:	TIN#:	DEA#:
Address:		
City:	State	Zip
Office Contact:	Email:	
Office phone:	Office fax:	

4. DIAGNOSIS INFORMATION (ICD 10 Code Required)

ICD 10 Code ()

****CMP/CBC/TSH/T4 within last 3 months****

5. PRESCRIPTION INFORMATION (requires new order every 12 months)

KEYTRUDA	PRE-MEDICATIONS	N/A
200 mg IV every 3 weeks	Acetaminophen	500mg 650mg 1000mg
400 mg IV every 6 weeks	Fexofenadine (Allegra)	180mg PO (or other non-sedating antihistamine)
Other: _____	Diphenhydramine (Benadryl)	25mg 50mg PO IV (requires driver)
Vital signs per HI Protocol	Methylprednisolone (Solu-Medrol)	40mg 80mg 125mg IV
Anaphylaxis & Hydration Management per HI Protocol	Prednisone	_____ mg PO
	Other	_____
	POST-MEDICATIONS	N/A
	Acetaminophen	500mg 650mg 1000mg
	Prednisone	_____ mg PO
	Other	_____

6. LABS

CBC w/Diff	Each Infusion	Other Frequency (specify): _____
CRP	Each Infusion	Other Frequency (specify): _____
CMP	Each Infusion	Other Frequency (specify): _____
ESR	Each Infusion	Other Frequency (specify): _____
Hepatic Panel	Each Infusion	Other Frequency (specify): _____
Renal Panel	Each Infusion	Other Frequency (specify): _____
Quantiferon TB Gold, annually, last completed (date): _____		
Other (specify): _____		

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE

DATE